



⚠ The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit <https://www.bcbsok.com/policy-forms/2019/BPSH32BVPIOKP.pdf> or by calling 1-866-520-2507. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$3,150 Individual/\$9,450 Family Out-of-Network: \$9,450 Individual/\$28,350 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. In-Network Preventive Health is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Network: \$6,650 Individual/\$13,300 Family Out-of-Network: Unlimited Individual/Unlimited Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. For a list of <u>network providers</u> please call 1-866-520-2507 or see www.bcbsok.com .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Virtual Visits are available. See your benefit booklet* for details.
	<u>Specialist</u> visit	40% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Freestanding Facility: 30% <u>coinsurance</u> Hospital: 40% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your benefit booklet* for details.
	<u>Imaging</u> (CT/PET scans, MRIs)	Freestanding Facility: 30% <u>coinsurance</u> Hospital: 40% <u>coinsurance</u>	50% <u>coinsurance</u>	

*For more information about limitations and exceptions, see the plan or policy document at <https://www.bcbsok.com/policy-forms/2019/BPSH32BVPIOKP.pdf>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/HIM/2019/2019_OK_6T_HIM.pdf	Preferred generic drugs	Preferred - 20% <u>coinsurance</u> Non-Preferred - 25% <u>coinsurance</u>	Retail - 25% <u>coinsurance</u>	Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at mail order. <u>Specialty drugs</u> limited to a 30-day supply. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. All Out-of-Network prescriptions are subject to a 50% additional charge after the applicable copay/ <u>coinsurance</u> . Additional charge will not apply to any <u>deductible</u> or out-of-pocket amounts.
	Non-preferred generic drugs	Preferred - 25% <u>coinsurance</u> Non-Preferred - 30% <u>coinsurance</u>	Retail - 30% <u>coinsurance</u>	
	Preferred brand drugs	Preferred - 30% <u>coinsurance</u> Non-Preferred - 35% <u>coinsurance</u>	Retail - 35% <u>coinsurance</u>	
	Non-preferred brand drugs	Preferred - 35% <u>coinsurance</u> Non-Preferred - 40% <u>coinsurance</u>	Retail - 40% <u>coinsurance</u>	
	Preferred <u>specialty drugs</u>	45% <u>coinsurance</u>	45% <u>coinsurance</u>	
	Non-Preferred <u>specialty drugs</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Freestanding Facility - \$300/visit plus 30% <u>coinsurance</u> Hospital - \$300/visit plus 40% <u>coinsurance</u>	\$1,500/visit plus 50% <u>coinsurance</u>	<u>Preauthorization</u> may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	\$200/visit plus 40% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$950/visit plus 40% <u>coinsurance</u>	\$950/visit plus 40% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required for non-emergency transportation; see your benefit booklet* for details.
	<u>Urgent care</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	None

*For more information about limitations and exceptions, see the plan or policy document at <https://www.bcbsok.com/policy-forms/2019/BPSH32BVPIOKP.pdf>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$400/visit plus 40% <u>coinsurance</u>	\$1,500/visit plus 50% <u>coinsurance</u>	Preauthorization required. Preauthorization penalty: \$500. See your benefit booklet* for details.
	Physician/surgeon fees	40% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Outpatient: Preauthorization may be required; see your benefit booklet* for details. Inpatient: Preauthorization required.
	Inpatient services	\$400/visit plus 40% <u>coinsurance</u>	\$1,500/visit plus 50% <u>coinsurance</u>	
If you are pregnant	Office visits	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Cost sharing does not apply to certain preventive services. Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	40% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$400/visit plus 40% <u>coinsurance</u>	\$1,500/visit plus 50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	30 visits/year. Preauthorization may be required.
	<u>Rehabilitation services</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization may be required. Outpatient: Combined 25 visit limit per benefit period for physical, speech, occupational therapy and muscle manipulation. Inpatient: 30 day maximum per benefit period. Preauthorization penalty: \$500.
	<u>Habilitation services</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Durable medical equipment</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization may be required.
	<u>Hospice services</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization may be required. Inpatient Preauthorization penalty: \$500.
	If your child needs dental or eye care	Children's eye exam	No Charge; <u>deductible</u> does not apply	Not Covered
Children's glasses		No Charge	Not Covered	One pair of glasses per year. See your benefit booklet* for details.
Children's dental check-up		Not Covered	Not Covered	None

*For more information about limitations and exceptions, see the [plan](https://www.bcbsok.com/policy-forms/2019/BPSH32BVPIOKP.pdf) or policy document at <https://www.bcbsok.com/policy-forms/2019/BPSH32BVPIOKP.pdf>.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (Unless the life of the mother is endangered)
- Acupuncture
- Bariatric surgery (For weight loss purposes)
- Cosmetic surgery (With exception of accidental injury repair and some instances for physiological functioning improvement of a malformed body member)
- Dental Care (Adult and Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (Except for diabetic subscribers)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document)

- Chiropractic care (Limited to 25 visits per calendar year.)
- Hearing aids (Limited to one for each ear every 48 months)
- Private-duty nursing (Limited to 85 visits per year)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-866-520-2507. You may also contact your state insurance department at 1-800-522-0071. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Oklahoma at 1-800-942-5837 or visit www.bcbsok.com. Contact the Oklahoma Department of Insurance at 1-405-521-2991 or www.oid.ok.gov.

Additionally, a consumer assistance program can help you file your appeal. Contact the Oklahoma Department of Insurance's Consumer Health Assistance Program at 1-800-522-0071 or visit <https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ok.html>.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-520-2507.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-520-2507.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-520-2507.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-520-2507.

—————*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*—————

About These Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$3,150
■ Specialist coinsurance	40%
■ Hospital (facility) copay/coins.	\$400 + 40%
■ Other coinsurance	40%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,150
Copayments	\$400
Coinsurance	\$3,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,710

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$3,150
■ Specialist coinsurance	40%
■ Hospital (facility) copay/coins.	\$400 + 40%
■ Other coinsurance	40%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,150
Copayments	\$0
Coinsurance	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$4,510

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$3,150
■ Specialist coinsurance	40%
■ Hospital (facility) copay/coins.	\$400 + 40%
■ Other coinsurance	40%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,700
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,000

The plan would be responsible for the other costs of these EXAMPLE covered services.



If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

Table with 2 columns: Language and Translation. Languages include Arabic, Burmese, Cherokee, Chinese, French, German, Hmong, Korean, Laotian, Navajo, Persian, Spanish, Tagalog, Thai, Urdu, and Vietnamese.



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We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>